62A-16-101. Title.

This chapter is known as the "Fatality Review Act."

Enacted by Chapter 239, 2010 General Session

62A-16-102. Definitions.

(1) "Committee" means a fatality review committee, formed under Section 62A-16-202 or 62A-16-203.

(2) "Qualified individual" means an individual who:

(a) at the time that the individual dies, is a resident of a facility or program that is owned or operated by the department or a division of the department;

(b) (i) is in the custody of the department or a division of the department; and

(ii) is placed in a residential placement by the department or a division of the department;

(c) at the time that the individual dies, has an open case for the receipt of child welfare services, including:

(i) an investigation for abuse, neglect, or dependency;

(ii) foster care;

(iii) in-home services; or

(iv) substitute care;

(d) had an open case for the receipt of child welfare services within one year immediately preceding the day on which the individual dies;

(e) was the subject of an accepted referral received by Adult Protective Services within one year immediately preceding the day on which the individual dies, if:

(i) the department or a division of the department is aware of the death; and

(ii) the death is reported as a homicide, suicide, or an undetermined cause;

(f) received services from, or under the direction of, the Division of Services for People with Disabilities within one year immediately preceding the day on which the individual dies, unless the individual:

(i) lived in the individual's home at the time of death; and

(ii) the director of the Office of Services Review determines that the death was not in any way related to services that were provided by, or under the direction of, the department or a division of the department;

(g) dies within 60 days after the day on which the individual is discharged from the Utah State Hospital, if the department is aware of the death; or

(h) is designated as a qualified individual by the executive director.

Enacted by Chapter 239, 2010 General Session

62A-16-201. Initial review.

(1) Within seven days after the day on which the department knows that a qualified individual has died, a person designated by the department shall:

(a) complete a deceased client report form, created by the department; and

(b) forward the completed client report form to the director of the office or division that has jurisdiction over the region or facility.

(2) The director of the office or division described in Subsection (1) shall, upon receipt of a deceased client report form, immediately provide a copy of the form to:

(a) the executive director; and

(b) the fatality review coordinator or the fatality review coordinator's designee.

(3) Within 10 days after the day on which the fatality review coordinator or the fatality review coordinator's designee receives a copy of the deceased client report form, the fatality review coordinator or the fatality review coordinator's designee shall request a copy of all relevant department case records regarding the individual who is the subject of the deceased client report form.

(4) Each person who receives a request for a record described in Subsection (3) shall provide a copy of the record to the fatality review coordinator or the fatality review coordinator's designee, by a secure method, within seven days after the day on which the request is made.

(5) Within 30 days after the day on which the fatality review coordinator or the fatality review coordinator's designee receives the case records requested under Subsection (3), the fatality review coordinator, or the fatality review coordinator's designee, shall:

(a) review the deceased client report form, the case files, and other relevant information received by the fatality review coordinator; and

(b) make a recommendation to the director of the Office of Services Review regarding whether a formal fatality review should be conducted.

(6) (a) In accordance with Subsection (6)(b), within seven days after the day on which the fatality review coordinator or the fatality review coordinator's designee makes the recommendation described in Subsection (5)(b), the director of the Office of Services Review or the director's designee shall determine whether to order that a formal fatality review be conducted.

(b) The director of the Office of Services Review or the director's designee shall order that a formal fatality review be conducted if:

(i) at the time of death, the qualified individual is:

(A) an individual described in Subsection 62A-16-102(2)(a) or (b), unless:

(I) the death is due to a natural cause; or

(II) the director of the Office of Services Review or the director's designee determines that the death was not in any way related to services that were provided by, or under the direction of, the department or a division of the department; or

(B) a child in foster care or substitute care, unless the death is due to:

(I) a natural cause; or

(II) an accident;

(ii) it appears, based on the information provided to the director of the Office of Services Review or the director's designee, that:

(A) a provision of law, rule, policy, or procedure relating to the deceased individual or the deceased individual's family may not have been complied with;

(B) the fatality was not responded to properly;

(C) a law, rule, policy, or procedure may need to be changed; or

(D) additional training is needed;

(iii) the death is caused by suicide; or

(iv) the director of the Office of Services Review or the director's designee determines that another reason exists to order that a formal fatality review be conducted.

Amended by Chapter 343, 2011 General Session

62A-16-202. Fatality Review Committee for a deceased individual who was not a resident of the Utah State Hospital or the Utah State Developmental Center.

(1) Except for a fatality review committee described in Section 62A-16-203, the fatality review coordinator shall organize a fatality review committee for each formal fatality review that is ordered to be conducted under Subsection 62A-16-201(6).

(2) Except as provided in Subsection (5), a committee described in Subsection (1):

(a) shall include the following members:

(i) the department's fatality review coordinator, who shall designate a member of the committee to serve as chair of the committee;

(ii) a member of the board, if there is a board, of the relevant division or office;

(iii) the attorney general or the attorney general's designee;

(iv) (A) a member of the management staff of the relevant division or office; or

(B) a person who is a supervisor, or a higher level position, from a region that did not have jurisdiction over the qualified individual; and

(v) a member of the department's risk management services; and

(b) may include the following members:

(i) a health care professional;

(ii) a law enforcement officer; or

(iii) a representative of the Office of Public Guardian.

(3) If a death that is subject to formal review involves a qualified individual described in Subsection 62A-16-102(2)(c) or (d), the committee may also include:

(a) a health care professional;

(b) a law enforcement officer;

(c) the director of the Office of Guardian ad Litem;

(d) an employee of the division who may be able to provide information or expertise that would be helpful to the formal review; or

(e) a professional whose knowledge or expertise may significantly contribute to the formal review.

(4) A committee described in Subsection (1) may also include a person whose knowledge or expertise may significantly contribute to the formal review.

(5) A committee described in this section may not include an individual who was involved in, or who supervises a person who was involved in, the fatality.

(6) Each member of a committee described in this section who is not an employee of the department shall sign a form, created by the department, indicating that the member agrees to:

(a) keep all information relating to a fatality review confidential; and

(b) not release any information relating to a fatality review, unless required or permitted by law to release the information.

Enacted by Chapter 239, 2010 General Session

62A-16-203. Fatality Review Committees for a deceased resident of the Utah State Hospital or the Utah State Developmental Center.

(1) If a qualified individual who is the subject of a formal fatality review that is ordered to be conducted under Subsection 62A-16-201(6) was a resident of the Utah State Hospital or the Utah State Developmental Center, the fatality review coordinator of that facility shall organize a fatality review committee to review the fatality.

(2) Except as provided in Subsection (4), a committee described in Subsection (1) shall include the following members:

(a) the fatality review coordinator for the facility, who shall serve as chair of the committee;

(b) a member of the management staff of the facility;

(c) a supervisor of a unit other than the one in which the qualified individual resided;

(d) a physician;

(e) a representative from the administration of the division that oversees the facility;

(f) the department's fatality review coordinator;

(g) a member of the department's risk management services; and

(h) a citizen who is not an employee of the department.

(3) A committee described in Subsection (1) may also include a person whose knowledge or expertise may significantly contribute to the formal review.

(4) A committee described in this section may not include an individual who:

(a) was involved in, or who supervises a person who was involved in, the fatality; or

(b) has a conflict with the fatality review.

Enacted by Chapter 239, 2010 General Session

62A-16-204. Fatality Review Committee Proceedings.

(1) A majority vote of committee members present constitutes the action of the committee.

(2) The department shall give the committee access to all reports, records, and other documents that are relevant to the fatality under investigation, including:

(a) narrative reports;

(b) case files;

(c) autopsy reports; and

(d) police reports, unless the report is protected from disclosure under Subsection 63G-2-305(10) or (11).

(3) The Utah State Hospital and the Utah State Developmental Center shall provide protected health information to the committee if requested by a fatality review coordinator.

(4) A committee shall convene its first meeting within 14 days after the day on

which a formal fatality review is ordered under Subsection 62A-16-201(6), unless this time is extended, for good cause, by the director of the Office of Services Review.

(5) A committee may interview a staff member, a provider, or any other person who may have knowledge or expertise that is relevant to the fatality review.

(6) A committee shall render an advisory opinion regarding:

(a) whether the provisions of law, rule, policy, and procedure relating to the deceased individual and the deceased individual's family were complied with;

(b) whether the fatality was responded to properly;

(c) whether to recommend that a law, rule, policy, or procedure be changed; and

(d) whether additional training is needed.

Amended by Chapter 445, 2013 General Session

62A-16-301. Fatality review committee report -- Response to report.

(1) Within 20 days after the day on which the committee proceedings described in Section 62A-16-204 end, the committee shall submit:

(a) a written report to the executive director that includes:

(i) the advisory opinions made under Subsection 62A-16-204(6); and

(ii) any recommendations regarding action that should be taken in relation to an employee of the department or a person who contracts with the department;

(b) a copy of the report described in Subsection (1)(a) to:

(i) the director, or the director's designee, of the office or division to which the fatality relates; and

(ii) the regional director, or the regional director's designee, of the region to which the fatality relates; and

(c) a copy of the report described in Subsection (1)(a), with only identifying information redacted, to the Office of Legislative Research and General Counsel.

(2) Within 20 days after the day on which the director described in Subsection (1)(b)(i) receives a copy of the report described in Subsection (1)(a), the director shall provide a written response to the director of the Office of Services Review and a copy of the response, with only identifying information redacted, to the Office of Legislative Research and General Counsel, if the report:

(a) indicates that a law, rule, policy, or procedure was not complied with;

(b) indicates that the fatality was not responded to properly;

(c) recommends that a law, rule, policy, or procedure be changed; or

(d) indicates that additional training is needed.

(3) The response described in Subsection (2) shall include a plan of action to implement any recommended improvements within the office or division.

(4) Within 30 days after the day on which the executive director receives the response described in Subsection (2), the executive director, or the executive director's designee shall:

(a) review the plan of action described in Subsection (3);

(b) make any written response that the executive director or the executive director's designee determines is necessary;

(c) provide a copy of the written response described in Subsection (4)(b), with

only identifying information redacted, to the Office of Legislative Research and General Counsel; and

(d) provide an unredacted copy of the response described in Subsection (4)(b) to the director of the Office of Services Review.

(5) A report described in Subsection (1) and each response described in this section is a protected record.

(6) (a) As used in this Subsection (6), "fatality review document" means any document created in connection with, or as a result of, a fatality review or a decision whether to conduct a fatality review, including:

(i) a report described in Subsection (1);

(ii) a response described in this section;

(iii) a recommendation regarding whether a fatality review should be conducted;

(iv) a decision to conduct a fatality review;

(v) notes of a person who participates in a fatality review;

(vi) notes of a person who reviews a fatality review report;

(vii) minutes of a fatality review;

(viii) minutes of a meeting where a fatality review report is reviewed; and

(ix) minutes of, documents received in relation to, and documents generated in relation to, the portion of a meeting of the Health and Human Services Interim Committee or the Child Welfare Legislative Oversight Panel that a fatality review report or a document described in this Subsection (6)(a) is reviewed or discussed.

(b) A fatality review document is not subject to discovery, subpoena, or similar compulsory process in any civil, judicial, or administrative proceeding, nor shall any individual or organization with lawful access to the data be compelled to testify with regard to a report described in Subsection (1) or a response described in this section.

(c) The following are not admissible as evidence in a civil, judicial, or administrative proceeding:

(i) a fatality review document; and

(ii) an executive summary described in Subsection 62A-16-302(4).

Amended by Chapter 343, 2011 General Session

62A-16-302. Reporting to, and review by, legislative committees.

(1) The Office of Legislative Research and General Counsel shall provide a copy of the report described in Subsection 62A-16-301(1)(b), and the responses described in Subsections 62A-16-301(2) and (4)(c) to the chairs of:

(a) the Health and Human Services Interim Committee; or

(b) if the individual who is the subject of the report was, at the time of death, a person described in Subsection 62A-16-102(2)(c) or (d), the Child Welfare Legislative Oversight Panel.

(2) (a) The Health and Human Services Interim Committee may, in a closed meeting, review a report described in Subsection 62A-16-301(1)(b).

(b) The Child Welfare Legislative Oversight Panel shall, in a closed meeting, review a report described in Subsection (1)(b).

(3) (a) Neither the Health and Human Services Interim Committee nor the Child

Welfare Legislative Oversight Panel may interfere with, or make recommendations regarding, the resolution of a particular case.

(b) The purpose of a review described in Subsection (2) is to assist a committee or panel described in Subsection (2) in determining whether to recommend a change in the law.

(c) Any recommendation, described in Subsection (3)(b), by a committee or panel for a change in the law shall be made in an open meeting.

(4) (a) On or before September 1 of each year, the department shall provide an executive summary of all fatality review reports for the preceding state fiscal year to the Office of Legislative Research and General Counsel.

(b) The Office of Legislative Research and General Counsel shall forward a copy of the executive summary described in Subsection (4)(a) to:

(i) the Health and Human Services Interim Committee; and

(ii) the Child Welfare Legislative Oversight Panel.

(5) The executive summary described in Subsection (4):

(a) may not include any names or identifying information;

(b) shall include:

(i) all recommendations regarding changes to the law that were made during the preceding fiscal year under Subsection 62A-16-204(6);

(ii) all changes made, or in the process of being made, to a law, rule, policy, or procedure in response to a fatality review that occurred during the preceding fiscal year;

(iii) a description of the training that has been completed in response to a fatality review that occurred during the preceding fiscal year;

(iv) statistics for the preceding fiscal year regarding:

(A) the number and type of fatalities of qualified individuals that are known to the department;

(B) the number of formal fatality reviews conducted;

(C) the categories, described in Subsection 62A-16-102(2) of qualified individuals who died;

(D) the gender, age, race, and other significant categories of qualified individuals who died; and

(E) the number of fatalities of qualified individuals known to the department that are identified as suicides; and

(v) action taken by the Office of Licensing and the Bureau of Internal Review and Audits in response to the fatality of a qualified individual; and

(c) is a public document.

(6) The Division of Child and Family Services shall, to the extent required by the federal Child Abuse Prevention and Treatment Act, as amended, allow public disclosure of the findings or information relating to a case of child abuse or neglect that results in a child fatality or near fatality.

Amended by Chapter 343, 2011 General Session